Maternal MORTALITY REPORTS

These case reports are taken from the files of the State Department of Public Health which, together with the California Medical Association, now sponsors the statewide studies of all maternal mortalities. Selected cases are here presented from time to time as a matter of interest and illumination to all physicians concerned with the practice of obstetrics. They are prepared by the Committee on Maternal and Child Care. It is hoped that a review of such significant cases will help to improve the welfare of future California mothers.

CASE NO. 4

THE PATIENT was 37 years of age, gravida 3, para 2. Her first pregnancy had been complicated by several episodes of vaginal bleeding and had terminated four weeks prematurely. The second pregnancy terminated with cramps and bleeding at the twenty-second week. Five years before her death the patient had had a dilatation and curettage for irregular uterine bleeding.

During the third pregnancy, the patient had two episodes of vaginal bleeding, one in the sixth month and one in the seventh. The second of these episodes led to admittance to hospital, and an obstetrical consultant there made a provisional diagnosis of a low-lying placenta or marginal placenta praevia (although the report notes no specific investigative techniques to confirm this). The consultant advised bed rest and careful observation and recommended that blood for transfusion be available. When the bleeding ceased in 24 hours, the patient was discharged from the hospital.

At the thirtieth week of pregnancy, the patient was admitted to the hospital in active labor and with ruptured membranes. The nurse's notes indicate that there was "quite heavy" bleeding at the time of admission, and this apparently continued during the two hours of labor required to accomplish spontaneous delivery of a child weighing 2 pounds 15 ounces. The records also indicate excessive bleeding during the delivery. The placenta was described as being delivered intact.

Shortly after delivery, the patient was transferred from the delivery room to a ward bed, where she was given ergonovine intravenously and one ampule of a vitamin K preparation. Intravenous infusion of 1,000 ml. of 5 per cent glucose solution was started. Again according to the nurse's notes, the patient continued to bleed heavily after the departure of the attending physician. He was called and returned about three hours after delivery, but the patient died one hour later—four hours postpartum.

There is no record of any order in the chart for crossmatching or for transfusion at any time. There is no record of any pelvic examination being done during the postpartum bleeding. The cause of death is stated on the death certificate as "Exsanguination due to retained placental fragment." Presumably, the secondary diagnosis was established by autopsy, but a copy of the autopsy report was not forwarded with the Maternal Mortality Study report.

COMMENT

The errors of omission in this case are blatantly obvious. Both the previous history and the conditions observed in the third pregnancy gave ample warning of the likelihood of the presence of a gravely dangerous hemorrhagic complication of pregnancy. Yet this warning was totally ignored at the time of her admission in labor and during her six hours of subsequent life—in the face of an obstetrician's recommendation during a previous bleeding episode that blood for transfusion be available. Apparently the extent of hemorrhage during the short labor and the delivery was either ignored or grossly underestimated. When the heavy bleeding continued postpartum, the patient was removed from the delivery room, although that is where the most efficient care could have been rendered. No attempt was made to determine the site of or the reason for the excessive bleeding; and the possibilities for both were multiple in this case. On hindsight, one judges that the patient's life might have been saved had simple intrauterine exploration (made virtually mandatory by the persistent postpartum hemorrhage) been carried out. Finally, when all indications were for blood transfusion, there had been at no time even an order for crossmatching. In this day of widely-distributed blood banks, failure to call upon their life-saving supplies for patients such as this one is still far too frequent. Herein lies the major reason why hemorrhage continues to be the number one killer of postpartum mothers.